NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
Application for Privileges
N.J.A.C. 13:35-4A.12

MEDICAL/PEDIATRIC SUBSPECIALTY SERVICES REQUIRING ANESTHESIA

Medical Procedures Requiring Anesthesia Services:

PRIVILEGE CRITERIA

1. Attestation (Attachment 1 - in attestation format provided)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number and type of medical procedures requiring anesthesia services which I performed in the last two years with acceptable results for patients of all age groups, except age groups specifically excluded from my practice, **plus** through additional material below.

2. Training (Attachment 2A and, depending upon privileges requested, Attachments 2B and 2C)

I am providing, as Attachment 2A, documentary evidence of **one** of the following:

(1) Current certification in internal medicine granted by the American Board of Internal Medicine or the American Board of Pediatrics or the American Osteopathic Board of Internal Medicine or the American Osteopathic Board of Pediatrics or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Successful completion of an ACGME/AOA accredited residency training program in internal medicine or pediatrics **OR**

(3) Supervised training in residency or fellowship or other equivalent experience in _____ **(another field) AND** active participation in examination process leading to certification in internal medicine or pediatrics.

Use of Laser (Attachment 2B):

In addition to documentation of general surgical training, for privileges for use of laser, I am providing, as **Attachment 2B**, documentary evidence of **one** of the following:

(1) Completion of a laser training program sponsored by an ACCME or AOA accredited provider of Category I CME documenting laser care, physics and clinical indications for utilization of the specific laser **and successful performance of laser procedures using the specific laser under direct clinical supervision**, or

(2) Documentation from the program director of an accredited residency training program attesting to the training in specific laser therapy during residency training.

PROCEDURES REQUIRING ADDITIONAL TRAINING

I have attached, as Attachment(s) 2C, documentary evidence of the required additional training for each of the following procedures, if privileges are requested for these procedures:

For the following requested procedures:

- Gastroscopy
- Colonoscopy

additional training: Completion of an accredited gastroenterology subspecialty training program.

For the following requested procedures:

- Bronchoscopy **(excluding with laser)** with biopsy
- Transbronchial Biopsy

additional training: Completion of an accredited pulmonary subspecialty training program.

3. Record Review/Clinical Observation (Attachment 3 and, depending upon privilege requested, Attachment 3A - in format provided):

References - Names, addresses and specialty, residency or observation only

I am providing the names, addresses and specialty of three plenary licensed physicians who will directly submit references addressing my current competence based on their personal knowledge obtained either during a residency training completed during the two years preceding the date of this application or through personal observation during the two years preceding the date of this application.

A. Reference for Requested Procedure(s) requiring additional training

I am providing the name, address and specialty of a privileged physician who has directly observed my successful performance or participation in the **requested** procedure(s). and whom I have asked to directly submit a reference addressing my current competence based on their personal knowledge obtained through personal observation of my successful performance or participation in the requested procedure.

4. Log of procedures (**Attachment 4A, for each privilege requested - in format provided**)

I am providing, as Attachment 4A, a **separate log** listing all patients for whom, in an office setting or licensed ambulatory care facility setting during the two years preceding

the date of the application, I performed each of the procedures for which I am requesting privileges. Each log includes a patient number, the type of anesthesia service provided, the surgery or special procedure performed and the date(s) of service. Patient names and other identifying data are redacted.

I am maintaining **in my office** a list or other means to identify the patient, based on the number included in the log.

Within each log, I have identified any patients contained in the log who have experienced complications relating to my performance of surgery or special procedures in an office setting or licensed ambulatory care facility setting and their resulting outcomes.

As part of the application for privileges process, from the logs I am providing, at least 5 cases, **with personal identifiers redacted**, that are representative of the type of procedures for which I requested privileges will be selected and I will be asked to provide patient records (or pertinent portions), along with a completed case summary form for each.

DELINEATION OF PRIVILEGES

I have checked the column on the left of those privileges listed below to indicate those procedures for which I do not hold hospital privileges and for which I am requesting alternative privileges to perform these procedure(s) in the office setting. I have attached additional materials, including documentation of successful completion of additional training, as was noted above as Attachments 2B, 2C, and 3A, if I am requesting privileges for the specific procedure which requires additional training, including use of laser.

Requested Privileges

GASTROENTEROLOGY

_____ Gastroscopy - **Requires additional training**
_____ Colonoscopy - **Requires additional training**
_____ Other - Please specify and provide supporting documentation on a separate page: ____

PULMONARY

_____ Bronchoscopy **(excluding with laser)** with biopsy - **Requires additional training**
_____ Transbronchial Biopsy (no lasers used) - **Requires additional training**
_____ Other *Please specify and provide supporting documentation on a separate page:* _____

OTHER

_____ Lumbar Puncture with anesthesia services

_____ Other - Please specify and provide supporting documentation on a separate page: ____

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me or if the materials submitted by me are willfully false, I am subject to punishment.

_____

Signature and printed name of Applicant Date

Below this line for Administration Use Only

Application Tracking Record:

Initial Receipt Date of Application _____
Transmittal Date to Outsourcing Entity _____
Supplemental Information Requested
Supplemental Information Received _____
Outsourcing Entity Recommendation _____
Outsourcing Entity Reviewer _____
Board Committee Review Date _____
Board Disposition Date _____